

7281

CERTIFICATE OF DEATH

07253

Reg. Dist. No.

| | | | | | | | |
|---|-----------------------------|--|---------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #1 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Freston Washington Brooks | | | | 4. DATE OF DEATH Month Day Year 6 1 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE Col | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/22/06 | 9. AGE (In years last birthday) 52 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George W. Brooks | | | | 14. MOTHER'S MAIDEN NAME Mae R. Brooks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX (If yes, give war or dates of service) XXXX | | 16. SOCIAL SECURITY NO. XXXXXX | | 17. INFORMANT George W. Brooks Address Easton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hr 2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-18 , 19 58 , to 6-1 , 19 58 , that I last saw the deceased alive on 5-21 , 19 58 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William L. Winters M.D. | | | | ADDRESS (Street, city or town, state) 210 E. DAVEN EASTON MD DATE SIGNED 6/3/58 | | | |
| PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/4/58 | | 22c. NAME OF CEMETERY OR CREMATORY Williamsburg Cem | | 22d. LOCATION (City, town, or county) (State) Easton Rt. 4, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md. ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE JUN 5 '58 | | 24b. REGISTRAR'S SIGNATURE W. D. Search | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7256

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | | | d. STREET ADDRESS <i>1413 S. Hanson Street</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>P</i> Last <i>Caulk</i> | | | | 4. DATE OF DEATH Month <i>June</i> Day <i>21</i> Year <i>1958</i> | | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>August 15, 1903</i> | 9. AGE (In years last birthday) <i>54</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Teaching</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William Pritchard</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Davis</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <i>Mr Albert V. Caulk Hunt</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>153.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ca of sigmoid</i> DUE TO (c) <i>5 yrs</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>8/20</i> 19 <i>58</i> , to <i>6/21</i> 19 <i>58</i> that I last saw the deceased alive on <i>6/21</i> 19 <i>58</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>P E Cox</i> | | | | ADDRESS (Street, city or town, state) <i>EASTON MD</i> DATE SIGNED <i>6/23/58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>P E Cox</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>June 24, 1958</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Mount Peace Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Philadelphia, Pa.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice Newman & Son Easton Md</i> | | | | 24a. REC'D BY REGISTRAR <i>DATE JUN 25 1958</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

| | | | |
|---|--|---|--|
| <p>1. Name of deceased: <i>John Doe</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of birth: <i>Jan 1, 1900</i></p> | | <p>4. Age: <i>56</i></p> | |
| <p>5. Date of death: <i>Dec 15, 1956</i></p> | | <p>6. Time of death: <i>10:30 AM</i></p> | |
| <p>7. Place of death: <i>Home</i></p> | | <p>8. Cause of death: <i>Heart Disease</i></p> | |
| <p>9. Immediate cause: <i>Myocardial Infarction</i></p> | | <p>10. Underlying cause: <i>Coronary Artery Disease</i></p> | |
| <p>11. Contributing cause: <i>Hypertension</i></p> | | <p>12. Manner of death: <i>Natural</i></p> | |
| <p>13. Signature of physician: <i>Dr. J. Smith</i></p> | | <p>14. Signature of registrar: <i>John Doe</i></p> | |
| <p>15. Date of completion: <i>Dec 16, 1956</i></p> | | <p>16. Office of Registrar: <i>State Department of Health</i></p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7257

Item 7 File #230 6-30-58 et

CERTIFICATE OF DEATH

07255

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton (RURAL)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | e. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Copper</u> Last <u>Copper</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 1, 1893</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yard work</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Louis Copper</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Martha Copper</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | |
| 16. SOCIAL SECURITY NO. <u>not listed in</u> | | 17. INFORMANT <u>Harold M Bowman (Employer)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary dilatation & hypertrophy</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>11:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton, Md.</u> DATE SIGNED <u>20 June 1958</u> | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u> | | PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> <u>Easton 16, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/10/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wickman Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton Rd. 2, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton, Md.</u> | | 24a. RECEIVED BY REGISTRAR <u> </u> DATE <u>JUN 25 58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

| | | | | | | | | | |
|------------------|--|---------------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 15 1882 | | Boston, Mass. | |
| Usual Residence | | Occupation | | Cause of Death | | Date of Death | | Place of Death | |
| 123 Main St. | | Teacher | | Heart Disease | | Jan 20 1927 | | Boston, Mass. | |
| Physician's Name | | Physician's Address | | Signature of Physician | | Signature of Registrar | | Signature of Witness | |
| Dr. J. Smith | | 456 Elm St. | | [Signature] | | [Signature] | | [Signature] | |
| Manner of Death | | Burial Place | | Burial Date | | Burial Time | | Burial Place | |
| Natural | | Cemetery | | Jan 22 1927 | | 10:00 AM | | Cemetery | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
This certificate is to be filed in the office of the Registrar of Vital Records, State of Massachusetts, and a copy thereof to be sent to the local health officer of the town or city in which the death occurred.

7258

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 316 South | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth B. Middle Dickerson Last | | 4. DATE OF DEATH Month 6 Day 14 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE Col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/9/00 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Holmes | | 14. MOTHER'S MAIDEN NAME Emma Adams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Charles Holmes | | Address Easton, Md | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure due to 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis due to DUE TO (c) Hypertensive disease | | INTERVAL BETWEEN ONSET AND DEATH 3 mos 3 yrs Not known |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |

| | | | |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE **J. Tyler Baker** M.D. **11 Earle Ave Easton, Md** **6-17-58**

PHYSICIAN'S NAME (Type) _____

| | | | |
|--|----------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF 6/17/58 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem. | 22d. LOCATION (City, town, or county) (State) Easton Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE James B. Ashwell | | 24a. REC'D BY REGISTRAR DATE JUN 26 1958 | 24b. REGISTRAR'S SIGNATURE W. B. ... |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 2231 7-25-58 at

07257

7259

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|-----------------------------|---|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot.</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot.</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cordova.</i> | | | |
| c. LENGTH OF STAY in lb <i>1 day.</i> | | | | d. STREET ADDRESS <i>1</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Jacob</i> Middle <i>J</i> Last <i>Dobson</i> | | | | 4. DATE OF DEATH Month <i>June</i> Day <i>9</i> Year <i>1958</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>Cal</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>April 6, 1904</i> | 9. AGE (In years last birthday) <i>54</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | |
| 13. FATHER'S NAME <i>Jacob J. Dobson, Sr.</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Rosie</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Lottie Dobson</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Lobar</i> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>3 day</i> | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>6/8/58</i> , 19 <i>58</i> , to <i>6/9/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6/9/58</i> , 19 <i>58</i> , and that death occurred at <i>3:07 PM</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>P E. Cox</i> | | | | ADDRESS (Street, city or town, state) <i>Easton, Maryland</i> | | | |
| PHYSICIAN'S NAME (Type) <i>P E. Cox</i> | | | | DATE SIGNED <i>6/10/58</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6-13-58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>New Chapel</i> | | 22d. LOCATION (City, town, or county) (State) <i>Easton, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>James D. Ashell, Easton, Md.</i> | | | | 24a. REC'D BY REGISTRAR DATE <i>JUN 11 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. Beach</i> | |

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1

7260

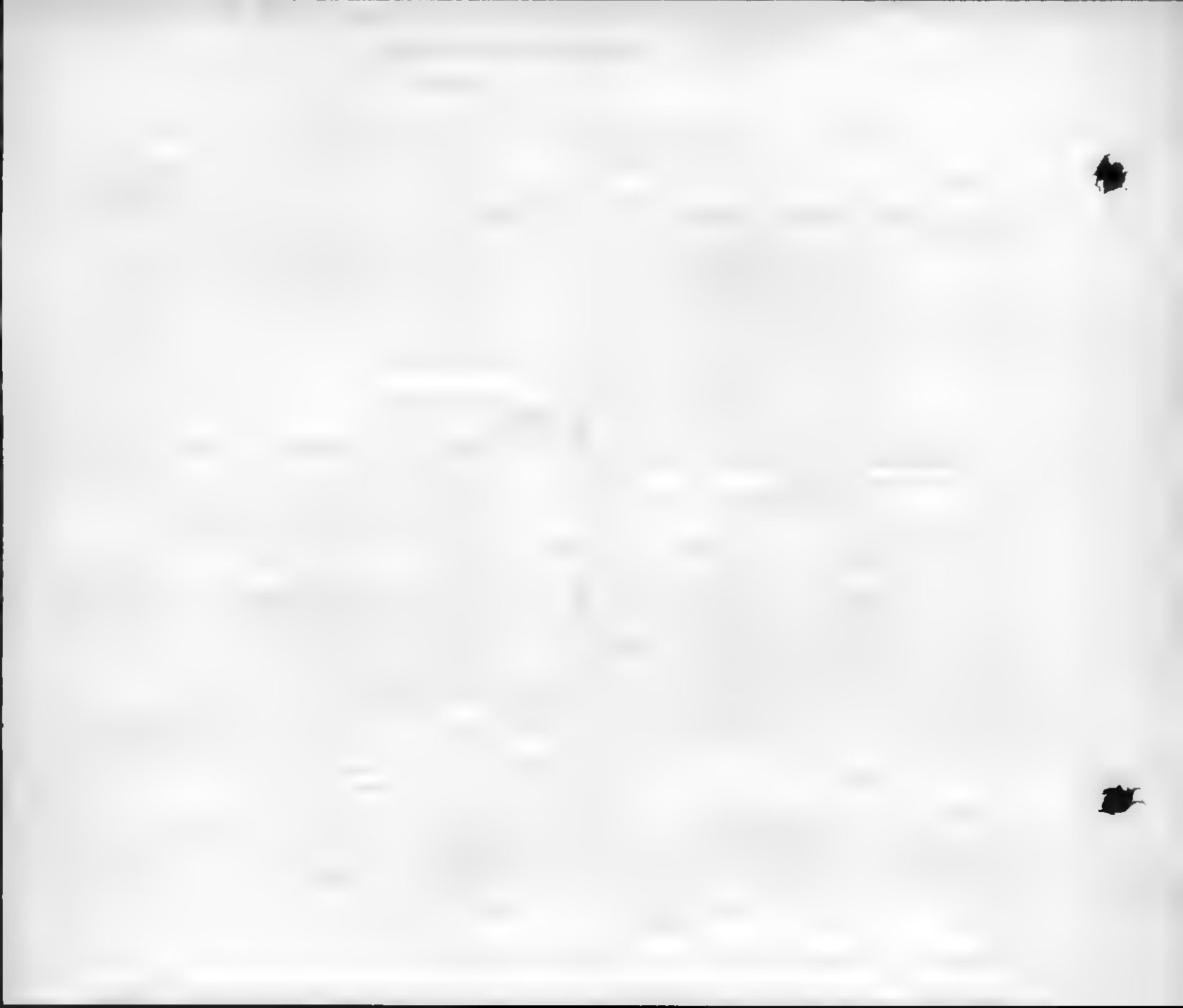
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY TALBOT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp. | | | | d. STREET ADDRESS 1 | | | |
| 3. NAME OF DECEASED (Type or print) Robert H. Dyott | | | | 4. DATE OF DEATH Month 6 Day 12 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept 9 1876 | |
| 9. AGE (In years less birthday) 81 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | | 11. BIRTH PLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME John Charles Dyott | | | |
| 14. MOTHER'S MAIDEN NAME Virginia Baker | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown | | | |
| 16. SOCIAL SECURITY NO. unknown | | | | 17. INFORMANT Robert C. Dyott - son Address same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Lacunes (stroke) 44" x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertension, treated with, the 54" DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 days before death | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from Sept 12, 1958 to June 12, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 1:35 P.M. from the causes and on the date stated above. | | | |
| 22a. BURNAL CREMATION, REMOVAL (Specify) June 14/1958 | | | | 22b. DATE THEREOF June 14/1958 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Oliver Cemetery | | | | 22d. LOCATION (City, town, or county) (State) St. Michaels Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Norman P. Marshall ADDRESS St. Michael Md | | | | 24a. REC'D BY REGISTRAR W. S. S. S. DATE JUN 16 58 | | | |
| 24b. REGISTRAR'S SIGNATURE W. S. S. S. | | | | 24c. REGISTRAR'S SIGNATURE W. S. S. S. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7261

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. LENGTH OF STAY IN life life | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 135 S. Washington St. | | | |
| d. STREET ADDRESS 135 S. Washington St. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Matilda Last Golt | | | | 4. DATE OF DEATH Month June Day 12 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH unknown | |
| 9. AGE (In years last birthday) 86 | | 10. IF UNDER 1 YEAR Months apx. Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John W. Beckwith | | | | 14. MOTHER'S MAIDEN NAME Susan Caulk | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none | | | | 16. SOCIAL SECURITY NO none | | | |
| 17. INFORMANT Mrs. Hilda Price, Easton, Maryland | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 1934 to 6/12/1958 that I last saw the deceased alive on 6/13/1958 and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/14/58 | | 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Easton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | | | 24a. REC'D BY REGISTRAR DATE JUN 18 58 | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7262

CERTIFICATE OF DEATH

Reg. Dist. No. 07260

| | | | | | | | |
|---|---------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>6 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u> | | | | d. STREET ADDRESS <u>None</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Wilbert</u> Middle <u>N</u> Last <u>Griffin</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 29, 1877</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | 10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Luther Griffin</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Spence</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>Not listed</u> | | | | 17. INFORMANT <u>Dr. J. J. ...</u> Address <u>...</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary disease</u> DUE TO (c) <u>Diabetes mellitus</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>P. S. Cox</u> | | | | ADDRESS (Street, city or town, state) <u>Pasadena Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>P. S. Cox</u> | | | | DATE SIGNED <u>6/27/58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/28/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u> | | 22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouleau</u> ADDRESS <u>Greensboro, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUN 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>...</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7263

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-----------------------------|--|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>SAMEL J. JACKSON</u> | | | | 4. DATE OF DEATH <u>June 20 1958</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 1, 1884</u> | 9. AGE (in years last birthday) <u>73</u> yrs | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. R.R. Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PA. RAILROAD</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Jackson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY F. FRANCES JOHNSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Bertha Jackson (wife)</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Ischemia in Chronic</u> DUE TO <u>Atherosclerosis general</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u> <u>Unk.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/13</u> , 19 <u>58</u> , to <u>6/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>58</u> , and that death occurred at <u>1:00</u> P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Federalburg, Maryland</u> DATE SIGNED <u>6/21/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JUNE 22, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>JJ Frampton Sr</u> ADDRESS <u>Federalburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 25 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7264

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Talbot.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Ann.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Ann Md.</u> <u>1700-2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>Not listed</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Therese</u> Middle <u>Jacob</u> Last <u>Jacob</u> | | | | 4. DATE OF DEATH Month <u>6</u> - Day <u>13</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Color</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 4, 1898</u> | 9. AGE (In years last birthday) <u>60</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 13. FATHER'S NAME <u>John Broadway</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lucy Wilson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO <u>Unknown</u> | | | |
| 17. INFORMANT <u>Robert D. Solomon</u> | | | | Address <u>1000 Cummins Rd. Easton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3.25x</u> DUE TO <u>Portent Softening</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:25 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert D. Solomon</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Savini Hospital, Baltimore, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>ROBERT D. SOLOMON</u> | | | | DATE SIGNED <u>6-16-58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>6/16/58</u> | | <u>Chesfield Cem</u> | | <u>Centerville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Smith</u> | | | | ADDRESS <u>Easton, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Goodrich</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07263

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>James</u> Last <u>James</u> | | 4. DATE OF DEATH <u>June 15 - 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 5, 1896</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Masterman</u> | | 11b. KIND OF BUSINESS OR INDUSTRY <u>Seamood</u> | |
| 12. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 14. FATHER'S NAME <u>Noah James</u> | | 15. MOTHER'S MAIDEN NAME <u>Romaine Stoddaway</u> | |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 17. SOCIAL SECURITY NO <u>220-12-2161</u> | |
| 18. INFORMANT <u>Mrs Elsie Lednum</u> | | Address <u>St Michaels Md</u> | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO (b) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) <u>Complicated by Bronchopneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:30 p.m.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert S. Solomon</u> M.D. | | ADDRESS (Street, city or town, state) <u>Senai Hospital, Baltimore 5, Md</u> DATE SIGNED <u>JUN 18 58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/18/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Oliver Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hamilton Harris</u> ADDRESS <u>St. Michaels</u> | | 24a. REC'D BY REGISTRAR <u>W. L. Leach</u> 24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 8/55



CERTIFICATE OF DEATH

07264

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. LENGTH OF STAY IN 1b <u>23 hr.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | e. STREET ADDRESS <u>None</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>KABARA</u> Last <u>KABARA</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1958</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 14, 1902</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> | |
| 13. FATHER'S NAME <u>PIAWAK WAVEZENACK</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY PIWOK</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr John Kabara</u> | | Address <u>Kabara</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>400.0</u> DUE TO <u>Congestive Heart Failure (anasarca)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/29</u> , 19 <u>58</u> , to <u>6/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>58</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>615 Boston St., Balto., Md.</u> DATE SIGNED <u>7/1/58</u> | | | |
| ACTUAL SIGNATURE <u>Robert W. Traver</u> | | M.D. <u>June 30, 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert W. Traver</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>7/3/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>615 Boston St., Balto., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marie Tinkowski</u> | | ADDRESS <u>1001 S. Remond</u> | |
| 24a. REC'D BY REGISTRAR <u>July 2 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>DeLoach</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7267

Item 1 Fill 7267 (1-25-58) at

Reg. Dist. No.

07265

| | | | |
|---|-----------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u> | | e. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Shelly</u> First <u>Kelly</u> Middle <u>Kelly</u> Last | | 4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-25-54</u> |
| 9. AGE (in years last birthday) <u>1</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>LEON KELLER JR.</u> | | 14. MOTHER'S MAIDEN NAME <u>Gladis Hill</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Gladis Hill</u> | | Address <u>Easton, md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>early meningitis</u> (c) <u>splenitis</u> DUE TO (c) <u>splenitis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>03</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE <u>L. M. WERTV</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>WERTV</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>6-25-58</u> | |
| 22a. BURIAL, CREMATION, RE-OVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Buried</u> | <u>6/18/58</u> | <u>Trappe, Cem</u> | <u>Trappe, md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Smith</u> | | 24. REC'D BY REGISTRAR DATE <u>JUN 30 1958</u> | |
| ADDRESS <u>Easton, md</u> | | REGISTRAR'S SIGNATURE <u>James R. Smith</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7268

CERTIFICATE OF DEATH

07266

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ALBON</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u> | | d. STREET ADDRESS <u>120 E. CENTRAL AVE.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>ELLIOTT</u> Last <u>KINDER</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEBRUARY 17/1881</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>JOHN THOMAS ELLIOTT</u> | | 14. MOTHER'S MAIDEN NAME <u>LYDIA H. DAVIS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>NONE</u> | |
| 17. INFORMANT <u>MISS HELEN KINDER</u> | | Address <u>FEDERALSBURG</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] — PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO <u>Carcinoma ovary - bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease and Hypertension</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>5-27</u> , 19 <u>58</u> , to <u>6-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>58</u> , and that death occurred at <u>5:40 P</u> M, from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| ACTUAL SIGNATURE <u>H. H. TRAVERS</u> M.D. | | <u>Federalsburg</u> <u>6-27-58</u> | |
| PHYSICIAN'S NAME (Type) <u>H. H. TRAVERS</u> | | <u>FEDERALSBURG, MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>JUNE 30, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson</u> | | ADDRESS <u>San Federalsburg, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |
| DATE <u>JUN 30 '58</u> | | <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7269

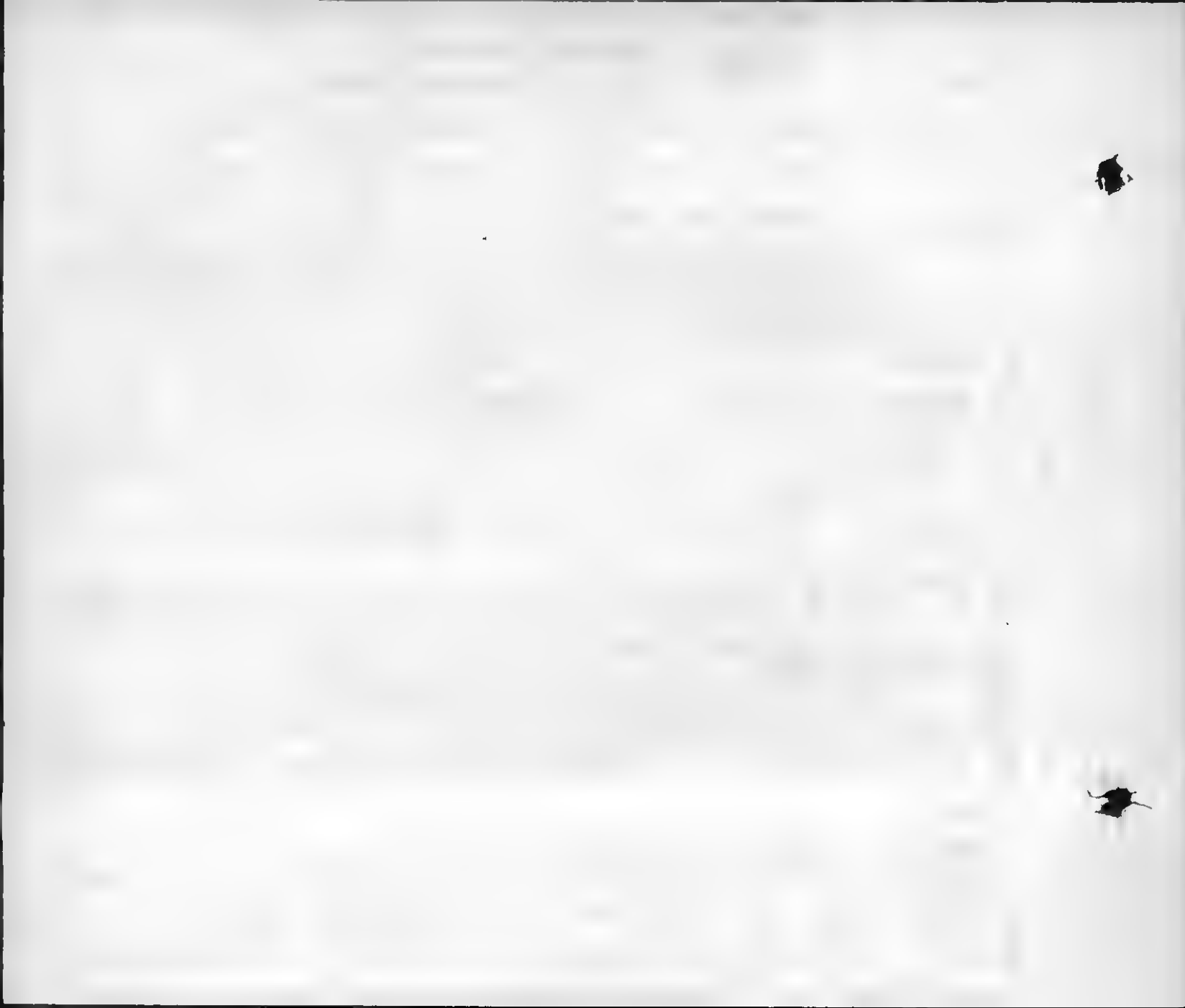
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> | | | |
| c. LENGTH OF STAY IN 1b <u>Thru 15 min.</u> | | | | d. STREET ADDRESS <u>P.O. #2 Box 124</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Watson</u> Last <u>Kirby</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>W. C.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 2, 1883</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>George Watson</u> | | 14. MOTHER'S MAIDEN NAME <u>Mattie Francis</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Emory Kirby - same - husband</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerotic heart disease & cardiac failure</u> DUE TO (b) <u>Dissecting aortic aneurysm</u> DUE TO (c) <u>Dissecting aortic aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>27 June</u> , 19 <u>58</u> , to <u>25 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>25 June</u> , 19 <u>58</u> , and that death occurred at <u>4:12 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Centerville, Maryland</u> DATE SIGNED <u>27 June 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Buried</u> | | <u>6/28/58</u> | | <u>Burnsville Cemetery</u> | | <u>Burnsville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Barton</u> ADDRESS <u>Centerville, Maryland</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE JUN 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7270

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---------------------------------------|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDISTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MILTON E. MARVEL</u> | | | | 4. DATE OF DEATH Month Day Year <u>JUNE 12 1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 13, 1892</u> | 9. AGE (In years last birthday) <u>65</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGENT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA. R.R.</u> | | 11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u> | |
| 13. FATHER'S NAME <u>WALTER MARVEL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SARAH HUTCHINS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no, or unknown) <u>UNKNOWN</u> | | | | 16. SOCIAL SECURITY NO. <u>716-03-1773</u> | | | |
| 17. INFORMANT Address <u>Helen B. Marvel (wife)</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> | | | |
| DUE TO (b) <u>Systolic & diastolic hypertension</u> | | | | (c) <u>(?)</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>57</u> , to <u>2 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 June</u> , 19 <u>58</u> , and that death occurred at <u>10:20 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Carlton, Maryland</u> DATE SIGNED <u>16 June 58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u> | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | |
| 22b. DATE THEREOF <u>JUNE 15, 1958</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>BISHOPVILLE CEMETERY</u> | | | |
| 22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE, MARYLAND</u> | | | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Houghton & Son, Federalsburg, Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u>DATE JUN 20 '58</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Alfred Search</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7271

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u> | | | | e. STREET ADDRESS <u>210 Goldsboro</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Arthur Miller</u> | | | | 4. DATE OF DEATH <u>June 7 1958</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 24 1886</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Miller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ray</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>unknown</u> | | | | 16. SOCIAL SECURITY NO <u>unknown</u> | | | |
| 17. INFORMANT <u>Miss Mary Haidcastle</u> | | | | Address <u>210 Goldsboro St Easton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | | | | | | |
| DUE TO <u>420.1</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | |
| DUE TO <u>Generalized Arteriosclerosis</u> | | | | | | | |
| (c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Nov-27, 1957</u> , to <u>6/7</u> , 1958, that I last saw the deceased alive on <u>6/7</u> , 1958, and that death occurred on <u>6/7</u> AM, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>L. J. Fylseder</u> M.D. | | | | <u>12 N. HANSON ST</u> <u>6/7/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>L. J. Fylseder</u> | | | | <u>EASTON, MARYLAND</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town or county) (State) | |
| <u>Cremation</u> | | <u>6-7-58</u> | | <u>City of Baltimore</u> | | <u>BALTIMORE</u> <u>Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>NORMAN HARSHALL</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR <u>JUN 11 1958</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | | DATE | | 24c. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7272 CERTIFICATE OF DEATH

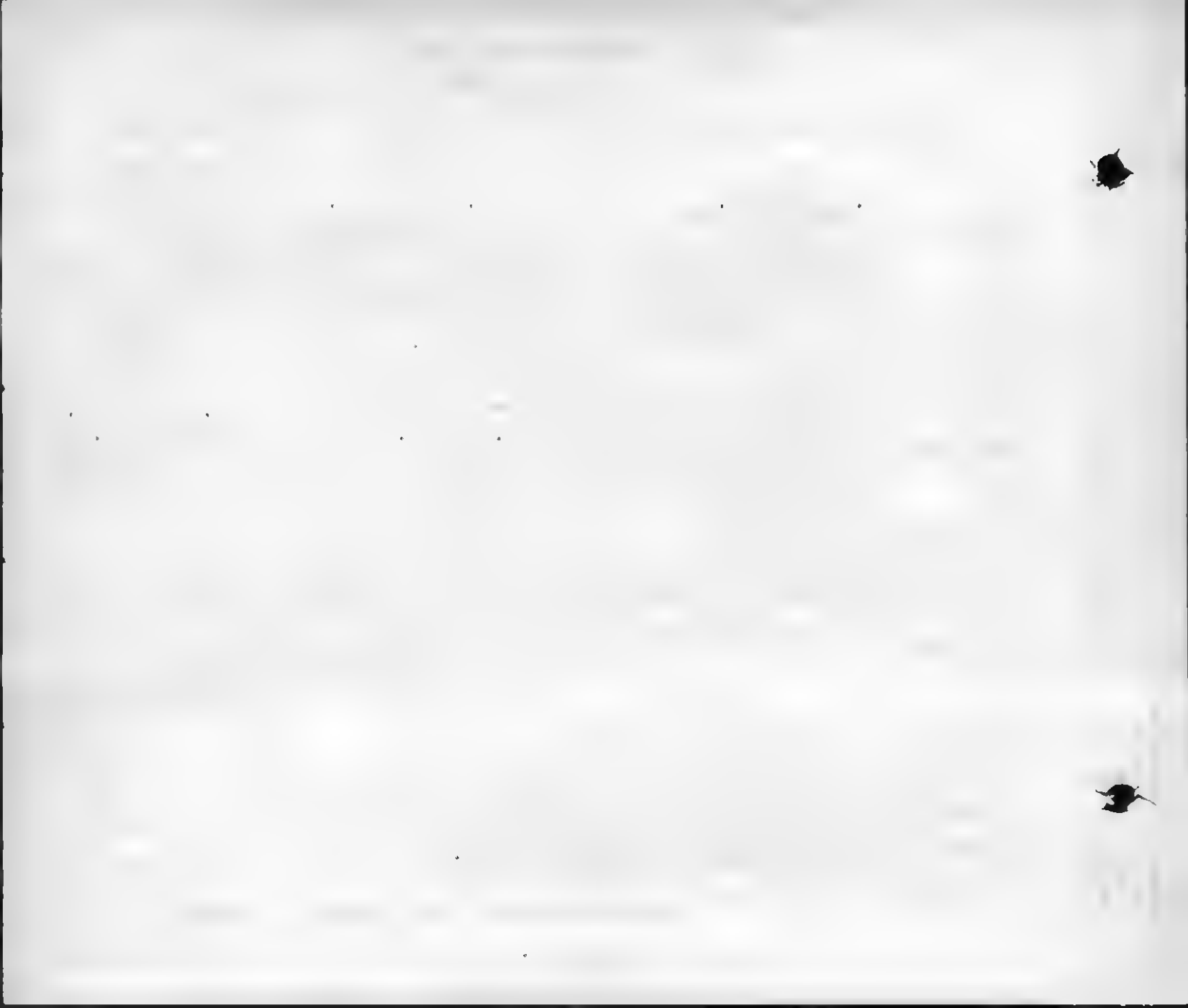
Reg. Dist. No.

07270

| | | | | | | | |
|---|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. LENGTH OF STAY IN 1b 12 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) E. Dover St. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle Bailey Last Minster | | | | 4. DATE OF DEATH Month June Day 26 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 30, 1909 | 9. AGE (In years last birthday) 48 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stewart | | 10b. KIND OF BUSINESS OR INDUSTRY Hotel | | 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph Minster | | | | 14. MOTHER'S MAIDEN NAME Edith Moser | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) none | | 16. SOCIAL SECURITY NO 185 09 5923 | | 17. INFORMANT Mrs. Ann K. Minster, | | Address E. Dover St. Easton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from Mar , 19 58 , to Apr , 19 58 , that I last saw the deceased alive on 26 June , 19 58 , and that death occurred at M , from the causes and on the date stated above ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED 27 June 58 | | | | | | | |
| ACTUAL SIGNATURE Thurston Harrison | | M.D. Carlton Ray Lund | | | | | |
| PHYSICIAN'S NAME (Type) Thurston Harrison Easton, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/30/58 | 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Easton, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Connel | | ADDRESS Easton, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 30 '58 | 24b. REGISTRAR'S SIGNATURE Alfred | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Biling 230 b-26-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

7273

1. PLACE OF DEATH
a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY IN 1b

1 hr

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Talbot

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oxford

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

d. STREET ADDRESS

e. S. RESIDENCE

ON A F P M

YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)~~James~~ Hughlett F Parrott

4. DATE OF DEATH

June

Month

Day

Year

18

19 58

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐NEVER MARRIED ☒

8. DATE OF BIRTH

Jul 13 1939

9. AGE (in years last birthday)

19 yrs

10. IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hunter

10b. KIND OF BUSINESS OR INDUSTRY

Ship Yard

11. BIRTHPLACE (State or foreign country)

Oxford Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Clarence Herbert Parrott Jr

14. MOTHER'S MAIDEN NAME

Hilda May Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219-36-5485

17. INFORMANT

Mrs Hilda M. Parrott, Oxford

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Fractured skull

DUE TO

(b) Auto accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 hr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month Day Year

Hour

6-18 1958

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Highway

20f. (City or town)

nr. Oxford

(County)

Talbot

(State)

Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐. Accident ☒ Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

Lara Welch

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

6-18-58

EXAMINER'S NAME (Type)

WELTY

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

June 21, 1958

22c. NAME OF CEMETERY OR CREMATORY

Greenwood

22d. LOCATION (City, town, or county)

Easton

(State)

Md

23. FUNERAL DIRECTOR'S SIGNATURE

[Signature]

ADDRESS

Easton Md

No. REC'D BY REGISTRAR

JUN 23 '58

24. REGISTRAR'S SIGNATURE

[Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 07272

7274

| | | | | | | | |
|--|---|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN 1b <u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>Royal Oak</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Roscoe</u> Middle <u>L</u> Last <u>Perkins</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 16, 1879</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>New Hampshire</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Nathaniel Perkins</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara Livingston</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or district service) <u>Yes W.W.</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Miss Clara Perkins - same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelogenous leukemia</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6 P</u> M, from the causes and on the date stated above. | | | | | | | DATE SIGNED <u>27 June 1958</u> |
| ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> | | M.D. <u>2195 Westminster ST</u> | | ADDRESS (Street, city or town, state) <u>Easton 16, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | | | |
| <u>Cremation</u> | <u>July 1, 1958</u> | <u>Louisa Park Cemetery</u> | | <u>Baltimore</u> | | <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuelton Harrison</u> | | ADDRESS <u>St. Michaels</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

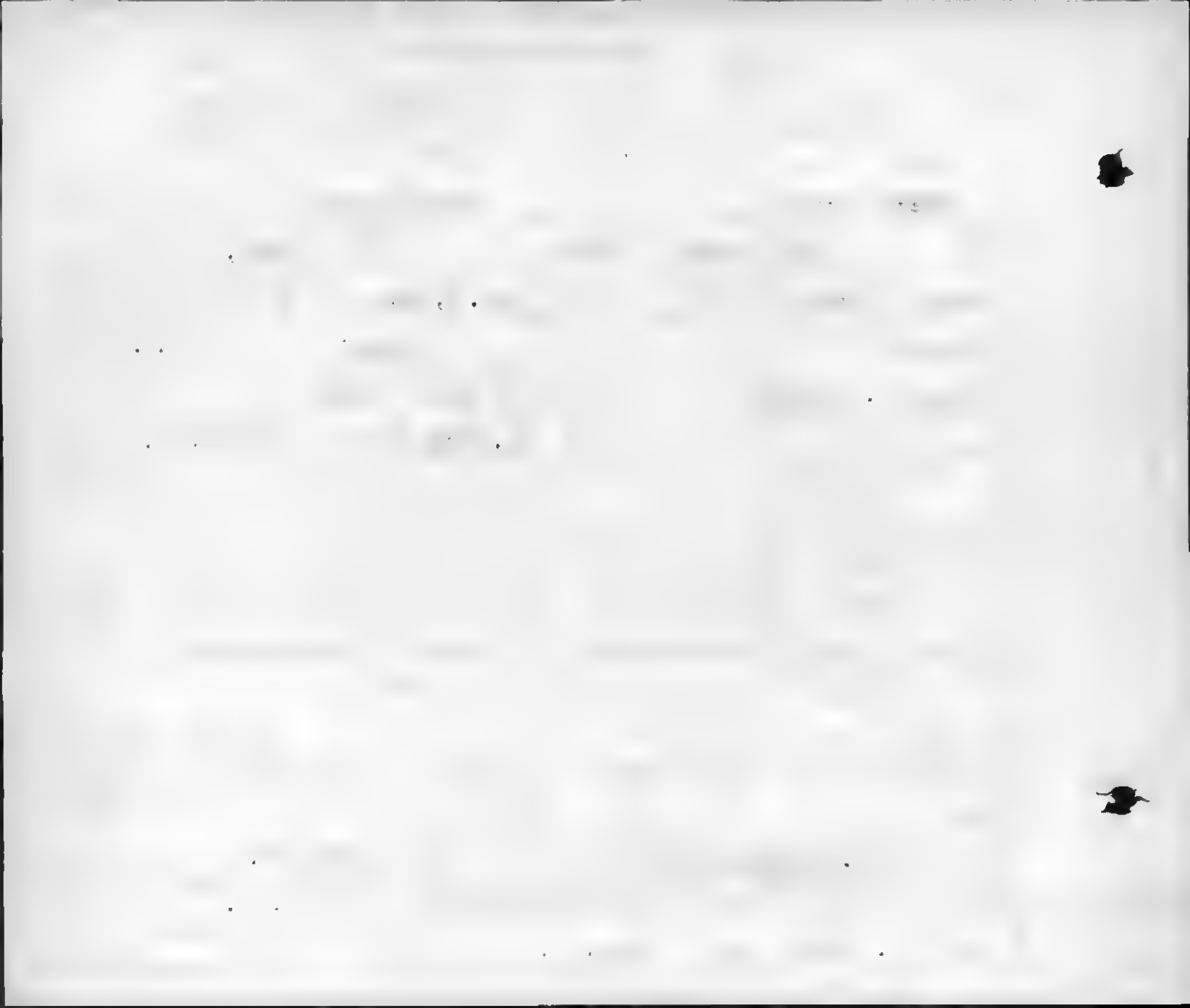
Reg. Dist. No.

07273

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|--|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | c. LENGTH OF STAY IN 1b years | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Talbot | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Idlewild Avenue | | | | | | d. STREET ADDRESS Idlewild Avenue | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) LULA SANGER SNIVELY | | | | | | 4. DATE OF DEATH Month June , Day 6 , Year 1958 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 4, 1878 | | 9. AGE (In years last birthday) 79 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Henry E. Sanger | | | | | | 14. MOTHER'S MAIDEN NAME Betty Pobst | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Jesse Fike | | | | Address Easton, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hypotension | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 12/ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21. I certify that I attended the deceased from January 1950 , to June 1958 , that I last saw the deceased alive on June 1958 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED June 1958 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. Thurston Harrison | | | | | | M.D. Easton, Md. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 9, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Fairview Church Cemetery | | | | 22d. LOCATION (City, town, or county) Cordova, Md. | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son | | | | | | ADDRESS Easton, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 11 '58 | | 24b. REGISTRAR'S SIGNATURE Overland | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7282

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Royal Oak</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before adm'ssion) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Hopkins Neck, Royal Oak</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Harvey</u> First <u>Thomas</u> Middle <u>Thomas</u> Last 4. DATE OF DEATH <u>6</u> Month <u>15</u> Day <u>1958</u> Year | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>48</u> yrs. 9. AGE (In years last birthday) <u>48</u> yrs. 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> 11. IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Ruben Thomas</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Wallace</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GSW chest</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>minutes</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot at close range - shotgun</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>6-15-58</u> Hour <u>6</u> a. m. <u>15</u> p. m. | | 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Royal Oak</u> (County) <u>Talbot</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James M. Kelly</u> | | M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>WELTV</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>6-25-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/15/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Royal Oak</u> | | 22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Goshell, Easton, MD.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 30 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Will. Allen</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



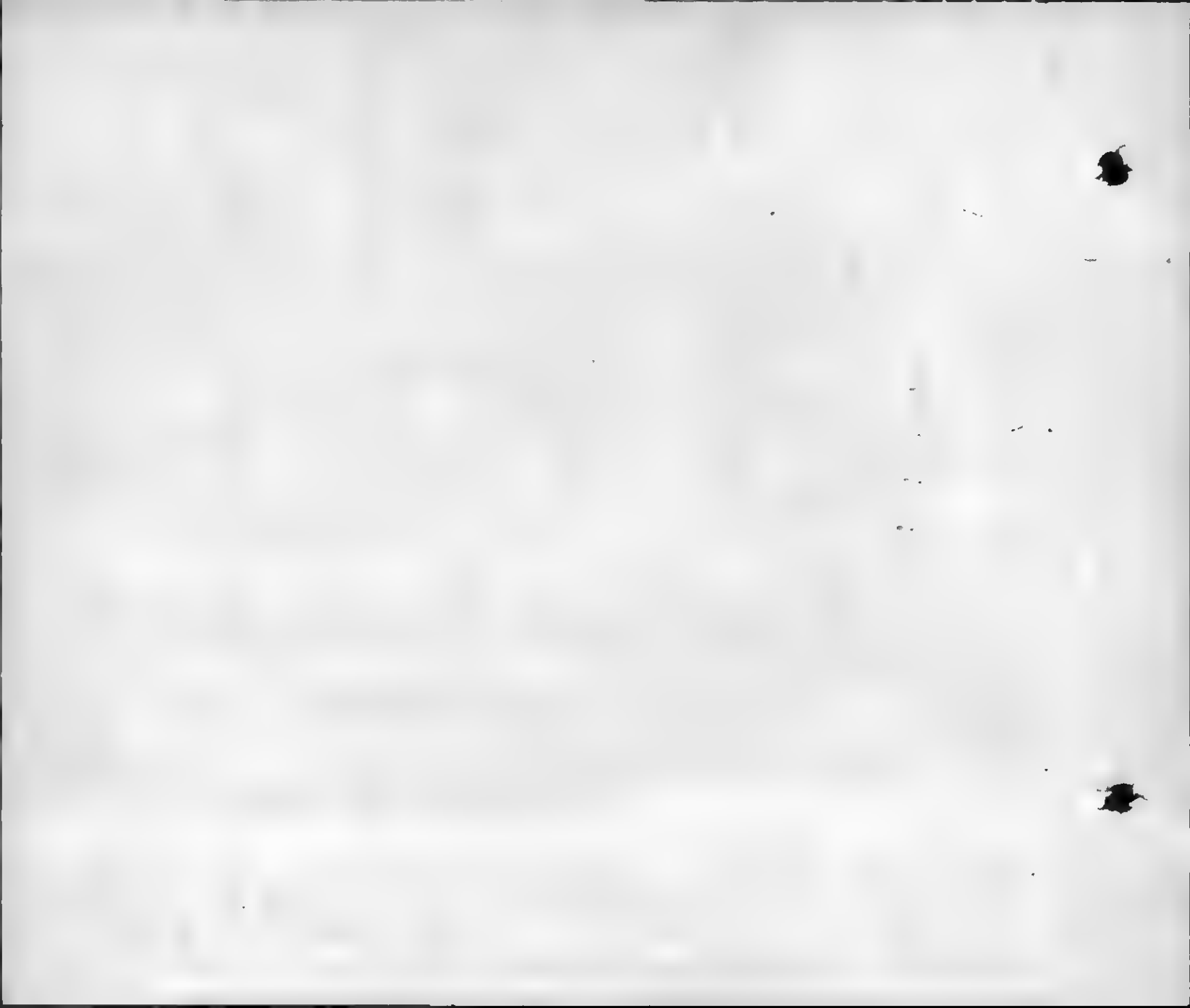
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7283

CERTIFICATE OF DEATH

Reg. Dist. No. 07275

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST MICHAELS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST MICHAELS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>TALBOT + MILL STREETS</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>SELINA</u> Last <u>TRICE</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1958</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB 14 1878</u> |
| 9. AGE (In years last birthday) <u>80 yrs</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>TALBOT CO. MD.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>TALBOT CO. MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>WILLIS T TRICE SR.</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNIE DAWSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs Rowena Jones</u> Address <u>St. Michaels, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Fail. 7 days</u> DUE TO (b) <u>Chronic Valvular Cardiac Disease, 5 yrs.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteomyelitis (2) Psoriasis (severe)</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1956</u> to <u>21 June 1958</u> , that I last saw the deceased alive on <u>21 June 1958</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. Lane Wright, M.D.</u> | | ADDRESS (Street, city or town, state) <u>Box 489, St. Michaels, Md</u> DATE SIGNED <u>6-22-58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>June 24, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hambleton Harrison, St. Michaels, Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u> | |



CERTIFICATE OF DEATH

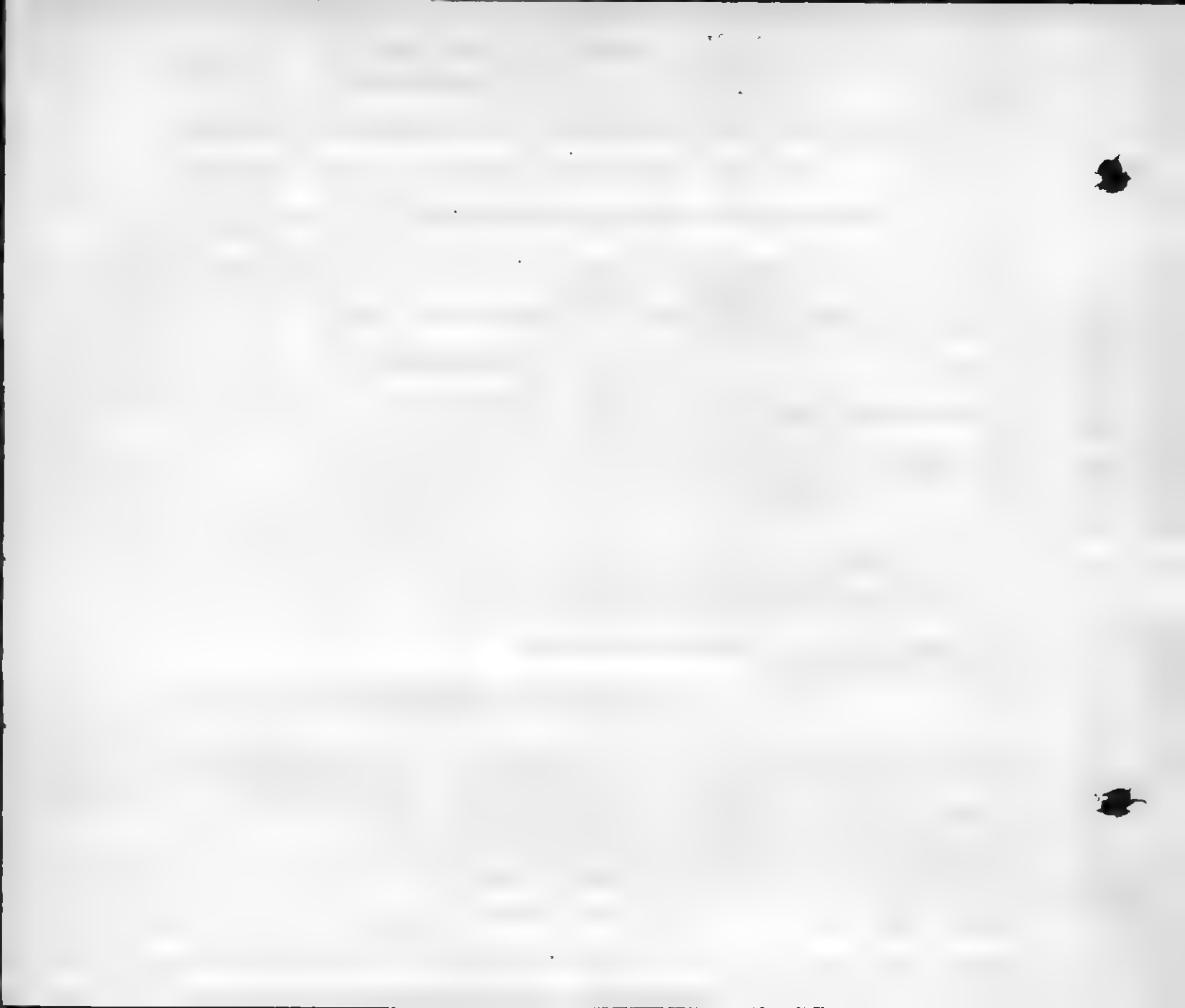
7276

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY: TALBOT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE: Maryland b. COUNTY: Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp. | | d. STREET ADDRESS Nm | |
| 3. NAME OF DECEASED (Type or print) First Orrie Middle Turner Last Turner | | 4. DATE OF DEATH Month June Day 11 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 14, 1875 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Turner | | 14. MOTHER'S MAIDEN NAME Fannie Connelly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Cora Turner - wife - Same | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & chronic pyelonephritis 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of urinary bladder - months. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 8:40 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R.D. Salamon (Pathologist) | | ADDRESS (Street, city or town, state) Lincoln Hospital, Baltimore 5, Md. | |
| PHYSICIAN'S NAME (Type) R.D. Salamon (Pathologist) | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-11-58 | 22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery | 22d. LOCATION (City, town, or county) (State) Federalburg, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.F. Frampton Son | | ADDRESS Federalburg Md | |
| 24a. REC'D BY REGISTRAR DATE JUN 16 '58 | | 24b. REGISTRAR'S SIGNATURE Al L. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7277 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William Warner</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/18/79</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Frank Craft</u> | | 14. MOTHER'S MAIDEN NAME <u>Hennietta Warner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Florence Roberts, North Beach Md</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 1956</u> to <u>June 1958</u> , that I last saw the deceased alive on <u>June 23, 1958</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>Hayward T. Webb</u> | | | |
| ACTUAL SIGNATURE <u>Hayward T. Webb</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u> </u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/26/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>New Chapel</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton, Bt 3, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Ashwell, Easton, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUL 1 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7278

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Caroline</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton</u> | | d. STREET ADDRESS <u>109 WEST CENTRAL AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>O.</u> Last <u>Williams.</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-22-1887</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Merchant</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Noble</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. <u>Not given</u> | |
| 17. INFORMANT <u>Mrs Madeline Williams (wife)</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>8 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6-2-1958</u> to <u>6-7-1958</u> , that I last saw the deceased alive on <u>6-7-58</u> T ^Y , and that death occurred at <u>2:40</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>124 Bloomingdale Ave</u> DATE SIGNED <u>Henry R. Trapnell</u> | | | |
| ACTUAL SIGNATURE <u>1407 Trapnell CP</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>Henry R. Trapnell</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>JUNE 10, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fraughton & Son, Federalburg, Maryland</u> ADDRESS | | 24a. REC'D BY REGISTRAR <u>Reich</u> | 24b. REGISTRAR'S SIGNATURE <u>Reich</u> |
| | | DATE <u>JUN 10 1958</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7279

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. LENGTH OF STAY IN TB <u>4 da.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | e. STREET ADDRESS <u>TRAPPE</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Wilson</u> Last <u>Wilson</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 16, 1886</u> 72 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS, OR INDUSTRY <u>Food-Packing</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Albert T. Wilson</u> | | 14. MOTHER'S MAIDEN NAME <u>Henrietta Blake</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>24-32-5581</u> | |
| 17. INFORMANT <u>Clara Wilson</u> Address <u>Wife</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post op Prostatectomy</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>Half hour</u> <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>R.C.V.D.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1958</u> , to <u>1958</u> , that I last saw the deceased alive on <u>1958</u> , and that death occurred at <u>1:54</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>P. E. Cox</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 22b. DATE THEREOF <u>6/6/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Trappe Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. [Signature]</u> ADDRESS <u>Cambridge, Md.</u> | | 24a. REC'D BY REGISTRAR <u>John W. [Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>John W. [Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

Vertical text on the right margin, possibly a filing number or date. Includes the number 111 at the bottom.

CERTIFICATE OF DEATH

07280

Reg. Dist. No.

7280

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Talbot</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | | | | c. LENGTH OF STAY IN 1b <i>19 20</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i> | | | |
| f. STREET ADDRESS <i>54 Graham, ST.</i> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Wilson</i> Last <i>Wilson</i> | | | | 4. DATE OF DEATH Month <i>June</i> Day <i>25</i> Year <i>1958</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>C</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>1913 Feb. 14, 1911/12</i> | |
| 9. AGE (In years last birthday) <i>45</i> yrs. | | IF UNDER 1 YEAR Months <i>45</i> Days <i>25</i> Hours <i>19</i> Min. <i>58</i> | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | |
| 13. FATHER'S NAME <i>Martin H. Wilson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Harriett Hazelton</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>Sister Martin H. Wilson father.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent metastatic</i> <i>171X</i> DUE TO <i>Carcinoma of cervix uteri</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <i>Birth</i> to <i>19</i> , that I last saw the deceased alive on <i>12-20-58</i> and that death occurred at <i>12:00 PM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> | | | | M.D. <i>219 S. Washington St. 25, Apr 58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i> | | | | ADDRESS (Street, city or town, state) <i>Easton 16, Maryland.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dushell</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>JUN 30 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>Richard Smith</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

Form with multiple lines for text entry, including fields for name, age, sex, date of death, and cause of death. The text is faint and mostly illegible.

